REPORT ON NATIONAL HEALTH POLICY WORKSHOP

VHAI

HIMACHAL PRADESH VHA

The Need for Partnership

There is growing recognition that partnership between governments and non-governmental organizations is an inescapable necessity for the attainment of Health for All by the year 2000. It is also felt that the time is opportune for intensifying such partnership, based on mutual understanding identification of appropriate roles, complementarity of actions, mutual learning by doing and full fledged cooperation. The World Health Organization is promoting, fostering and strengthening such partnership.

HFA Leadership/IM 11

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COMMUNITY

A

REPORT

ON THE

NATIONAL HEALTH POLICY WORKSHOP

HELD IN HIMACHAL PRADESH FROM 03 - 05 DECEMBER 1987.

SUMMARY FINDINGS AND RECOMMENDATIONS OF THE NATIONAL HEALTH POLICY WORKSHOP HELD IN HIMACHAL PRADESH FROM 03 - 05 DECEMBER 1987

The Workshop ended with a consolidated report prepared by all the groups incorporating the broad recommendations that emerged from the deliberations. On the whole, everybody agreed that :

1 There is a need to identify existing voluntary organisations in Himachal Pradesh and to share responsibilities between the Government and the local NGOs, for the health of the community. It was also agreed that both the government and the NGOs would prepare a list of NGOs in each block and pass this on to the District Health Officer.

2 The District Health Officer will invite the voluntary organisations concerned to attend all the meetings on 'planning of government health programmes' in the District.

3 The Director of Health Services, will inform voluntary organisations about the training programmes which take place at HPWTC Shimla, so that they could participate.

4 The referral system from periphery to the district level should be strengthened. A new system should also be evolved where any case referred either by voluntary organisations or sub-centre staff should be given preference at the hospital. Importantly, feedback should be given to the person who has sent the case. It is also vital to strengthen the support system for Primary Health Care, without which the whole health system may collapse.

5 For special vertical programmes in a particular area, the government and voluntary organisations together should plan the targets and work jointly to achieve the desired goals.

6 The State's Information System needs thorough revision. Reports from the periphery should be brief and structured. Only essential facts should be given.

It is also essential to evolve a new Information System in which the voluntary sector plays an integral role. It was agreed that unless the Information System was strengthened, monitoring of health care will remain very difficult.

7 Occupational health hazards in unorganised sectors like agriculture need to be investigated, and some kind of compensation should be made available to seriously affected workers.

8 Wide spread misuse of drugs such as steroids, antibiotics, phenobarbitones and tranquilisers, needs to be curtailed through thorough vigilance, and strict punishment given to offenders. Though drug licensing is strict in Himachal Pradesh, yet it is not rigorously enforced; the same is true of the Food Adulteration Act. Voluntary Health Organisations could serve as watch-dogs against these malpractices.

9 Coordination among different sectors; various departments within the government; and also between the government and NGOs working in the same centre, should be streamlined.

10 The training programmes at various levels and the supervision and support needed for the orientation of the workers at peripheral level, requires revision. A programme for continuing education must be planned.

11 While discussing the reallocation of funds for the Primary Health Centres and District Hospitals, it was recommended that more funds be made available at the Primary Health Centre level.

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INTRODUCTION

The NATIONAL HEALTH POLICY (NHP) statement was approved by both the Houses of Parliament at the end of 1983. In the last 40 years of independence, many Working Groups on Health have recommended various ways and means to improve the health of the nation. It was only through this policy statement that these recommendations could find a place in the planning process. The National Health Policy has raised the hopes of those concerned with India's poor health situation.

Meaningful and idealistic terms such as 'social justice', 'equal distribution' and 'health for all' have gone into the making of the policy statement; but whether these concepts would really be put into practice is yet to be seen.

'Collaboration with non-governmental organisations in implementing the National Strategy of Health for All' was the thrilling theme of the Technical Discussion of the World Health Assembly held on 11 May 1985. There is now no doubt that the government and the voluntary organisations are fully convinced of the need for partnership for effectively meeting the health needs of the people.

In 1986, the Voluntary Health Association of India(VHAI) put forward a proposal to the Ministry of Health and Family Welfare, Government of India to hold National Health Policy Workshops in various states. This was approved and accepted by the Government, and the workshops were subsequently organised.

OBJECTIVE OF THE WORKSHOP

The objective of the workshop was to formulate measures to implement the National Health Policy at all levels.

SPECIFIC OBJECTIVES

The specific objectives defined were:

1) To disseminate information about the NHP amongst:
   i) Government Health functionaries at different levels;
   ii) Voluntary Organisations.

2) To identify critical issues and the gaps that exist in the implementation of the policy;

3) To enhance the role perception at all levels (for programme management) as well as promoting leadership for Health for All;

4) To strengthen the intersectoral coordination amongst various agencies to achieve the health goals laid down.

The workshop also aimed at motivating the participants to :

1) Identify the gaps and critical issues of their area in implementing the National Health Policy;

2) Initiate necessary intersectoral linkages between the government and the non-government agencies;

3) Support and implement actions towards fulfilling the roles as leaders to strengthen the National Health Policy;

4) Improve the efficacy of the existing health services at all levels, by appropriate solutions; and

5) Create awareness amongst Health for All leaders of their area, with improved personal communication and motivation.

PRE-PLANNING

In the pre-planning phase, the Voluntary Health Association of India tried to identify State Voluntary Health Associations (SVHAs), who would be ready to take the responsibility of holding such workshops. It was clear that this would give a good opportunity for them to strengthen their membership as well as bring forth their viewpoints to the state governments.

To start with, it was essential to print the National Health Policy Statement and make it available to all the State VHAs. To this end, a small booklet depicting the elements of the NHP was designed and distributed. Charts, illustrations and organisational charts on the health care system at the national level were produced by VHAI as part of an educational kit for participants.

It was also decided that from each district of the state there would be one representative each from the Government and the Voluntary sectors. These participants were expected to collect information on the general

perception of Primary Health Care in their areas. This was done only to make them see the inadequacyof the services provided and to realise that unless the people became aware, they cannot ask for better services. It was also intended that the questionnaire issued to the participants would highlight some of the bottlenecks present in the delivery of the health care system and would initiate discussions in the workshop.

METHODOLOGY OF THE WORKSHOP

The whole workshop was participatry in nature and it was a good learning experience, both for the organisers as well as the participants. Apart from the keynote addresses on the main theme, the emphasis was on group work, where ideas were exchanged and the interaction of the participants encouraged individual thinking, resulting in the development of partnership amongst themselves.

PARTICIPANTS

One government health functionary, for example a District Health Officer, and one member of a voluntary organisation from each district of the state attended the workshop. In Himachal Pradesh, the number of the districts being 12, there were 12 government officials and 12 members from voluntary organisations. The total number of participants at the Himachal Workshop was 67 (as per annexe XVI) out of which there were 20 resource persons, 15 local persons and 5 members from Delhi.

DETAILED REPORT OF THE WORKSHOP

Day 1 : Inaugural Function:

At the inaugural function, all the key officials of the Himachal Health Department were present. This included the hon'ble Minister for Health, Mr Kaul Singh Thakur, who inaugurated the Workshop by lighting a lamp.

In his inaugural speech, Mr Kaul Singh Thakur outlined the critical areas in the field of health care in Himachal Pradesh and urged the voluntary organisations present, to come forward and help the Himachal Pradesh Government in its efforts to provide primary health care to the people of the State.

He praised the efforts made by the Voluntary Health Association of India (VHAI) and the Himachal Pradesh Voluntary Health Association (HPVHA) to bring together the voluntary organisations and

the government officials to discuss the bottlenecks in the implementation of the National Health Policy; he expressed the hope that the deliberations of the workshop would lead to valuable recommendations which would be acted upon by the government and the voluntary sector. While promising all support to the voluntary organisations, the Health Minister hoped that after the workshop it would be possible to draw up a plan of collaboration between the government and the voluntary sector.

Deliberating on the status of the health programmes, Mr Kaul Singh Thakur highlighted specific areas, like blindness, tuberculosis, leprosy, mother and child care and family welfare, where voluntary organisations could play a crucial role in helping the government in implementing the National Health Policy.

Earlier in the session, Mr S.S.Banolta, President of HPVHA, while welcoming the Health Minister, assured that HPVHA would do everything possible for achieving a better working relationship with the government. Dr Amla Rama Rao introduced the objectives of the VHAI and its role in these workshops. Dr Kshama Metre of Chinmaya Tapovan Trust spoke about the HPVHA and its role in health programmes.

Mr Ajay Prasad, Secretary, Ministry of Health, briefly emphasised the need for voluntary organisations to come forward and help the government in reaching health services to the people of HP. He expressed a keen interest in receiving a 'plan of action' for forging some effective links between the voluntary and the government sectors.

The inaugural session ended with an informal exchange, over a cup of tea between the Health Minister and the participants.

SCIENTIFIC SESSION

The next session involved scientific presentations on various health issues. This was to initiate thinking on the problems facing us and how effective implementation of health programmes could be possible, as outlined in the National Health Policy.

The first speaker was Dr C.L. Malhotra, Director, Health Services, H.P. He vividly described Himachal's health scenario. Tracing the history of the health services back to the British period, when Himachal Pradesh was a summer

resort for government officials, he enumerated the health problems that Himachal continues to encounter as a tourist attraction.

Dr N K Vaidya, Head of the Department of Preventive & Social Medicine, Indira Gandhi Medical College, Shimla, deliberated on the basics of the NHP and explained the relationship between the NHP programmes and the infrastructure that existed in Himachal Pradesh. He also highlighted the bottlenecks in the implementation.

Dr R.M. Bali, President of the Indian Medical Association, Himachal Chapter, and the Family Planning Association of India, gave his valuable suggestions for better linkage between the government and the non-governmental organisations. He focussed on several issues in the health field which could be taken up by the voluntary organisations for better results. He pointedly reminded the government of the dangers of irrational and hazardous combinations of drugs by multinational corporations and their reckless dumping and marketing of such medicines in Indian markets. He also pointed out that unless there are voluntary organisations working at various levels hand-in-hand with the government officials, it might not be possible to develop better understanding and ensure proper functioning of the health care system.

In the post-lunch session, Dr Hardev Singh, Principal of Health & Family Welfare Training Centre, gave a presentation which focussed on intersectoral coordination in health care programmes. He defined clearly how other sectors of the economy could contribute towards raising the standard of health. For example, the agricultural sector could contribute by raising production, thereby improving the nutrition situation. Dr Hardev Singh also outlined the role of voluntary organisations in bringing about better intersectoral cooperation.

Dr Darshan Shankar from the NGO sector spoke on the 'Potential for community involvement and self-reliance in p imary health care by revitalizing local health tradition'. He made it very clear that a massive infrastructure for delivering primary health care exists in our country, as a tradition. The influx of modern medicine and western ideologies of health care has eroded our system and our planners have overlooked this massive potential. Since there is no systematic study or census of people involved in the traditional methods of health care, it is not possible to give any development inputs into it. On the contrary, our present health care system has not grown out of the past but has been thrust upon us, as a result of which there are problems such as

'unmotivated health workers', 'expensive medicines' etc. These are proving to be a formidable hindrance in improving the health status of our country. Dr Darshan Shankar impressed upon the participants that modernisation means upgrading of the existing system of health care and not the thrusting of an alien system upon the existing one.

Dr Darshan Shankar's presentation proved to be an effective trigger to the imagination of the participants. Dr Kshama Metre of the Chinmaya Tapovan Trust and Mr Dharamveer Singh of the Rural Centre for Human Interest shared their perceptions with the participants.

Dr Vanaja Ramprasad read a paper focussing on the nutrition programmes for pregnant women, nursing mothers, and children, especially in tribal, hilly and backward areas. She emphasised the need for better nutrition education strategies and provision of better nutrition care during pregnancy.

Mr Kapil Dev Sud, a leading lawyer, of the Himachal Pradesh High Court and a pioneer in public interest litigation, briefed the participants on the role of law in the implementation of the NHP. Following the briefing, there was an animated question-answer session. Participants sought the counsel of Mr Sud on several specific cases. Some of the points raised by the speakers focused on :

- The need for adequate training of MPWs to fulfill the expectations of villagers in a sub-centre situation;
- Imparting such knowledge which can be applied;
- Strengthening of linkages between peripheral workers with the middle level and top level workers in order to remove the sense of isolation from which most of the field workers suffer;
- Strengthening the referral system so that neither doctors nor the specialist-hospitals are bogged down with the treatment of common ailments which could be taken care of at a lower level; and an adequate feedback mechanism from the specialist-hospitals to the VHW level so that a patient from the village, after receiving attention from the specialist, can get an effective follow up from the VHW;
- For reorienting our approach to health care, the present approach in making the beneficiary villagers dependent on health services as against making them self-reliant;

- To question the strategy of our family planning programme which is based on giving incentives which make the people feel that the VHW or whoever is propogating the small family norm is doing so out of his or her own interest, otherwise why should he or she pay for it?
- Health workers working under the pressure of completing targets have a tendency to give wrong information to people, for example, in the family welfare programme, the health workers are advocating sterilization instead of spacing and other measures to reduce infant mortality.

The session ended after a brief discussion.

Day 2 : GROUP DISCUSSIONS

Three groups were formed consisting of an equal number of government and voluntary sector participants. The group was given a briefing before the start of group work. The theme of the discussions for the group was "Identify the gaps and critical issues in the implementation of National Health Policy in your state and suggest ways to overcome those issues".

SESSIONAL OBJECTIVE

1 Identify the essential components of health policy;

1.1 list the components of care;

1.2 supportive process required for primary health care, such as:

1.2.1 referral service;

1.2.2 community participation;

1.2.3 intersectoral coordination, and

1.2.4 collaboration between NGOs and government, and information system.

2 Broadly analyse the contributions of existing programmes and schemes to achieve the goal of 'Health for All'; and

3 List other gaps and issues which are important in implementation of the policy.

They were also told to identify all the health problems existing in their areas and to find out the gaps and bottlenecks in achieving the goal of NHP. They were also told to select their own chairman and a reporter. The groups then started working, and finally in the evening, were to present their reports.

The group continued to work for the whole of the second day, and the next morning, all the groups presented their reports. Thereafter, in the afternoon a consolidated report was prepared incorporating the recommendations of the various groups.

Annexe 1

GROUP 1

The group felt that the greatest impediments to the smooth implementation of the National health Policy were ideological differences, political interference, wrong interpretation of the policy, and poor intersectoral coordination.

There was great concern about the political interference which was found at all levels. There was an imbalance in the expansion and opening of health centres. Dispensaries were opened under pressure from politically influential people rather than based on the health needs of the people of different areas. Gross disparities therefore existed between health needs and health services provided.

It was felt that health policy makers were often not aware of nor oriented towards public health, and they could not recognise the various component and the health problems faced by the communities. There was a suggestion that the decision makers of health policy must necessarily be health professionals trained in or oriented in public health so that they understand the health situation, its causes, the health needs, and be aware of the various methodologies and strategies for implementation.

Need for intersectoral coordination

There is no forum for discussion between the government and the voluntary health organisations, at various levels of the government. This was also absent between the different departments of the government. It was felt that the government was not giving due respect and recognition to activities of voluntary agencies, and that without any changes in the policies of agriculture, industry, education, food and supplies, the NHP cannot be implemented properly.

Job responsibilities of health functionaries have not been correctly defined. The training programme of health workers in several instances is ineffective and not needbased. Regarding the location of the health workers, it was pointed out that it was very important for the health workers to be located in the areas of their operation and not away from the community. Many of the health functionaries preferred to live in urban centres rather than face the realities and hardships of a rural set up. The interpersonal relationship of health workers - at the grassroot level - with the members of the community should be cordial and good.

Facilitating people's organisation

There was a need to facilitate the setting up of the Mahila Mandals, Youth Forums or Yuvak Kendras, so as to provide an opportunity to the members of the community to come together, know each other, communicate better and to work together.

Health issues needed to be discussed by the people to build awareness. The role of the wormen in the community was most important in ensuring health and survival of the family in particular and the community in general. The workers should be of good moral character and integrity and without any vested interest so that his or her advice was taken seriously and the community was moved to co-operate. The communities should be awakened to demand their rights and privileges to understand their duties and responsibilities, and to fight against various malpractices seen in the communities.

Water Supply

Potable water supply system should be the responsibility of and under the control of health department or of the health officers and not under the PWD.

Occupational Health Hazards

There is a great need to investigate into health hazards in agricultural occupations and ensure that safety measures are taken and adequate compensation is made available to the workers if they were found to be suffering from serious occupational health hazards.

Any violation of ConsumerRights should be instantly brought to the notice of the authorities concerned.

Drugs

1 Supplies: There was inadequate budget allocation. The amount of essential medicines made available to the government health institutions was inadequate.

2 Misuse: Misuse of drugs such as steroids, antibiotics, phenobarbitones and tranquilizers was widely prevalent. Apart from the indiscriminate use of these medicines even by qualified people, they were being prescribed by the practitioners of indigenous medicines and were available from any chemist's shop over the counter in contravention of the provisions of Drugs and Cosmetics Act, and Pharmacy Act. There were many instances where samples issued by the Pharamaceutical companies, expired drugs, costly tonics with high alcohol content and other ingredients in subtherapeutic dozes, medicines exclusively meant for use in the government dispansaries and

hospitals, were sold in the open market. There were several instances where drugs and vaccines were not stored properly as a result of which their efficacy and potency were lost. Medical officers did not have the power to apprehend the culprits in this respect. People must be encouraged to be more vigilant against all these social crimes. Offenders must be penalised by cancelling their licences, imposing fines and confiscation of the stocks. The names of the offenders should be made public so that the innocent customers did not extend their patronage to them. No doubt, the provisions of drug licensing were strict but they were seldom enforced rigorously. The revelation of the Lentin Commission recently made known is a glaring example of the wide prevalence of malpractices. There was an urgent need to curb this menace and the voluntary health organisations should serve as a watch-dog against any such exploitation in the name of medicines and health. The district level authority should be made accountable. The practice of buying bulk medicines by calling tenders and accepting lower rate, rather the lowest rate, often led to compromises being made with regard to quality.

Foods

Substandard and adulterated foods are often sold through government approved shops and the offenders often go unpunished. Food supplies from FCI and other agencies, and the government recognised shops should be examined by taking samples for investigations. Large scale adulteration and substandard quality of foods neutralise any gain that might have been achieved by health programmes and promotion work. The community should be made aware of its rights in this respect. There is rampant cheating in weights and measures too. Violation of consumer rights should be brought to the notice of the authorities concerned.

Curse of liquor

The curse of liquor on community life is a distressing and a well known fact. Liquor is destroying the fabric and structure of a healthy social life. Liquor not only destroys the economic status of the family but also nullifies, in its spate, whatever gains are achieved by the implementation of the various health programmes. The group also discussed the role played by and the encouragement given by the Central and State Governments in opening liquor shops for revenue gains all over the state, especially in the hill and tribal areas. The mushrooming of liquor shops was having a disastrous effect on the health of the individual, family and the society at large.

Prohibition was no answer to wipe out this satanic influence. In addition to educating the public about the ill-effects and the evils liquor consumption might bring in, it was also suggested that no liquor shop be opened or sanctioned unless two-thirds of the voters in a panchayat gave their consent in writing for this.

Annexe 2

GROUP II

The following points were highlighted:

PROBLEMS

- faults in planning;
- targets of various national programmes;
- lack of coordination among different government sectors;
- lack of recognition of voluntary agencies;
- lack of supervision in difficult areas;
- lack of supplies in peripheral institutions;
- CHVs, TDS etc. which are voluntary show more and more interest in entering into government sectors;
- lack of meetings/interaction between voluntary sector and government sector organisations, mostly at the peripheral levels;
- poverty, illiteracy, ignorance, fear in the community; and
- lack of strengthening of voluntary agencies.

SOLUTIONS

While making policies, it is necessary that representatives of the public be taken into consideration. National Programmes should not only be target-oriented with the aim of achieving the goal of 'Health for All' but also fulfil it on the basis of 'quality' rather than 'quantity'. This can be achieved with coordination between the government and voluntary agencies, mostly at the peripheral levels.

District paramedical staff should have a district centre, so that they can be trained and then posted in the very same district with a view to serving the community. There should be proper coordination among various departments of the Government, particularly Public Health, Education, Irrigation, Agriculture, and Animal Husbandry, etc. There should be due recognition to the existing NGOs. Even if there is no NGO existing at any given place some dedicated local persons can be selected and they could form 'action groups' which can be strengthened through training and help implement the various national health programmes.

More emphasis should be given to preventive, promotive and rehabilitative services because curative services, such as medicines, cannot sometimes reach

everybody in different areas. These preventive and promotive services can be provided with the help of voluntary agencies. NGOs should supervise the work of CHVs and TBAs in difficult areas, where health workers or supervisory staff are unable to visit.

There should be regular meetings between the government and NGOs, particularly at peripheral levels, so that problems and achievements could be discussed in detail and concrete plan worked out for further progress.

To improve the health of the community, we should first remove, by health education, the fears that exist in the minds of the people due to age-old customs and traditions.

Annexe 3

GROUP III

Though most of the points have been touched upon by Group I & II, this group felt that some of the important ones needed emphasis.

The group was of the view that for people's involvement, voluntary organisations need cooperation from various angles. The attitude therefore should be complementary rather than competitive. No authoritarian and prejudiced opinions or ideas should interfere in matters and decisions aiming at common goals. Very often, voluntary organisations find that the government show interest only when family planning is one of the components of the goal. Otherwise, they do not show much interest at the local level. The government officials on the other hand felt that if the voluntary organisations also involved the local officials at the local level, instead of directly approaching somebody at the top of the hierarchy, then there could be better interpersonal relationship.

The group then talked about establishing credibility with the people. It was felt that even the government has failed in this task, which can be achieved by sustained and repeated efforts. The people feel that they have been let down by various departments in the past. They therefore look upon everybody approaching them, with great suspicion.

Most of the untapped resources have been talked about, but one important point needs to be stressed upon, i.e. the lack of understanding. In many blocks one could sense a lack of understanding between the health department and the Aanganwadis. The existing barriers between them should be broken. Intersectoral involvement at the peripheral level has already been discussed. Only one very important point pertaining to Himachal Pradesh has probably not been mentioned, i.e. communication at the peripheral level. This has to be improved if the health services have to reach the remote areas.

The DGHS made us realise that the infrastructure, i.e. number of PHC-MPWs etc. in HP, as far as the periphery is concerned, is not too bad, but the impact is not felt at grassroot level. This might be because of the lacuna in training and selection of the people. Even in the case of posting and accountability of medical officers and administrators, many of them felt that there is always political influence. If health has to reach the grassroot level, then political influence has to be stopped. Then comes the question of training. We may ask ourselves if the training that we impart, for the type of services they are supposed to provide in the periphery, is sufficient and proper. The

group also felt that a lot of stress has to be given to practical application. The trainers should inspire the trainees to move to peripheral areas. There is restricted mobility for medical staff to reach the periphery for referral services. While there are jeeps and vans for other national programmes for important referral programmes like these, the mobility is a problem. If regular transport is provided then doctors will make visits and there would be proper referral services available to the subcentre once a week, and a very good supervisory control can be exercised. Another bottleneck in the infrastructure is the lack of drugs. Very often the subsentres are without drugs, vaccines and contraceptives. As a result of this, complete infrastructure is actually getting wasted many a time, and the health workers tend to lose their interest.

We have to develop a smooth referral system where the general patients are separated from the referral patients, so that a person coming from a remote village for special investigation gets due time and attention from the specialists. Most of the time, in 'exclusive hospitals for tertiary care' the time of the team of doctors/super-specialists is wasted in treating common ailments. As a result, the poor villager who has travelled three or four days to reach a specialist in a super-specialist hospital, gets no time at all. The load of OPD therefore has to be reduced by treating people at different levels. There should be a good feedback and followup of the referral mechanism. A patient from HP who gets diagnosed in AIIMS, Delhi, should have the facility of follow up right upto the VHW. Otherwise there is no use in spending so much in the investigation of that patient.

Now we come to the problem of nutrition. The National Health Policy says that adequate nutrition should be provided to all. We have a lot of food production but we lack in proper distribution. This needs to be looked into. Agricultural production in HP, especially pulses and vegetables, needs to be increased. We should also encourage poultry farming and dairying for generating income.

In nutrition education, we would like to emphasise a few points such as anaemia, nutrition, hookworm, sanitation, the practice of boiling rice and then throwing away its water by which a lot of vitamins are lost.

The use of iodized salt has to be reviewed. In the prevention of food adulteration, vigilance has to be strictly enforced. The food in this state comes from other states; where the food crosses the border, it should be checked for adulteration.

In regard to the Drug Control Act, a few points are to be noted: The Drug Inspector is the only one authorised for enforcing the Drug Control Act. The District Medical Officer has no authority to initiate action effectively. Proper authority should also be given to the District Medical Officer to take action against the offenders. Wrong advertisements on foods and tonics should be banned on radio and TV through government control. Unnecessary advertisements of irrational and hazardous drugs should be banned. All medicines belonging to all systems - allopathic, ayurvedic etc. - should come under the purview of the Drug Control Act.

The health information syst em should be simple and uniform so that every worker at every level understands it, and it percolates from the bottom to the top. We should strengthen the method of supervision of the work done - just quantity should not be a decisive criterion, and there should be some way for evaluating the quality too.

A mention has to be made about health insurance. LIC has now started a new scheme for those below the poverty line, where people can be referred to by recognised persons, and insured against disease free of cost.

It appears that the available legislations are also ineffective. Sanitation and epidemic laws have to be amended and enforced strictly, as also the Lepers Act.

Another point to be noted is traditional medicine. HP has a rich source of herbs. We should have some documentation on these: types, usage, availability,etc.

Alcoholism is yet another point of importance. Of all people who drink alcohol, about 1 to 2% are alcoholics. That means, they are diseased and have some chemical dependency. Something must be done about these alcoholic people because it is their family which is most likely to get destroyed.

There is no institute or hospital in HP for treating the handicapped. There should be at least one, at a central place. There should be certain basic specialist-services available to the community at the field level also.

Lastly, all aspects should be given importance - mental, spiritual, social and economic, and not just the physical aspect alone.

Annexe 4

General physiography, selected health & socio-economic indicators

of

HIMACHAL PRADESH

A) Physiography

Area : HP has an area of 55,673 Km.

HP is situated in the northwest corner of India, right in the lap of Himalayan ranges. It is surrounded by Jammu & Kashmir in the north, Uttar Pradesh in the South east, Haryana in the South, and Punjab in the West. In the East, it forms India's boundary with Tibet. The state is mountainous, with altitudes ranging from 460 to 6400 m. above sea level. It has a deeply dissected topography, a complex geological structure and a rich temperate flora in sub-topical latitudes.

B) Health & Socio-economic indicators

1	Population (in '000) as on 1.3.1980 (census)	4280.818
	i) Male	2169.931
	ii) Female	2110.887
2	Decennial growth rate	23.071
3	Sex ratio(Number of females to 1000 males) 1981	973
4	Rural population (in '000) 1981	3954.847
5	Urban population (in '000) 1981	325.971
6	Crude birth rate(SRS) (combined) 1983	32.9
	Rural	33.6
	Urban	22.2
7	Crude death rate(SRS) (combined) 1983	10.3
	Rural	10.5
	Urban	6.3
8	Infant mortality rate (combined) 1982	68
	Rural	70
	Urban	42
9	Expectation of life at birth (both sexes)	
	1976-80	
	Male	56.6
	Female	58.1
10	Literacy rate (percentage) 1981 (total)	54.9
	Male	42.48
	Female	53.19
		31.46

Annexe 4 : contd - General physiography, selected health and socio-economic indicators of HP

11	No. of districts in the state	12
12	No. of towns (1986)	56
13	No. of development blocks (1980-81)	69
14	No. of villages (inhabited) 1981	16,807

Annexe 5

District-wise, sex-wise village health guides trained since 1977-78 and working as on 31 March 1986

District	Total no. of Guides trained since 1977-78			Total no. of guides working as on 31 March 1986.		
	Male	Female	Total	Male	Female	Total
Bilaspur	240	7	247	206	7	213
Chamba	413	14	427	395	13	408
Hamirpur	433	72	505	305	54	359
Kangra	1369	249	1618	925	170	1095
Kinnar	68	29	97	40	9	49
Kullu	286	41	327	262	23	285
L & Spiti	53	2	55	43	--	43
Mandi	606	43	649	513	43	556
Shimla	489	83	572	299	35	334
Sirmaur	349	20	369	316	17	333
Solan	283	5	288	203	3	206
Una	387	50	437	254	30	284
IGMC	--	--	--	56	14	70
HP State	4976	615	5591	3817	418	4235

Annexe 6

District-wise, year-wise list of PHCs opened from '82 to '86

Name of the District	1982-83	1983-84	1984-85	1985-86
Bilaspur	Kuhanal		Berthin	Punjgain
Chamba	--	1) Holi	Garola	1) Dharwas
		2) Kakira		2) Salooni
Hamirpur	--	Bhareri	--	--
Kangra	1) Lamba-gaon	1) Panch-rukha	1) Darini	1) Kasba-Kotla
	2) Jawali	2) Rey	2) Baroh	2) Lunj
	3) Rehan	3) Dhira	3) Paragpur	3) Kotla
	4) Mahakal	--	--	4) Khera
Kinnar	--	--	--	--
Kullu	--	Sainj	1) Bhutti	--
			2) Nither	--
L & Spiti	Udaipur	--	--	--
Mandi	1) Kataula	Dehar	1) Nehar	1) Barot
	2) Jamni	--	2) Gohar	2) Marhi
	--	--	3) Rewalsar	3) Baggi
Shimla	--	1) Kupwi	Sawra	1) Nerwa
	--	2) Dodra	--	2) Taklech
	--	3) Dhargaura	--	3) Dhami
Sirmaur	Majra	Haripurshar	--	Dhamla
Solan	Ramsaher	Jagon	Darlaghat	--
Una	Amb	--	--	Bangana
HP State				
Total nos. opened	11	13	12	15
Target	11	12	12	15
Achievement (percentage)	100	108.33	100	100

790 HP 100

Annexe 7

District-wise, year-wise targets and achievements of new leprosy cases detected from 1982-83 to 1985-86

District	1982-83			1983-84			1984-85			1985-86		
	Target	Achie-vement	%	Target	Achie-vement	%	Target	Achie-vement	%	Target	Achie-vement	%
Bilaspur	50	9	18.00	15	3	20.00	10	4	40.00	10	10	100.00
Chamba	600	39	6.50	80	47	58.75	80	24	30.00	80	20	25.00
Hamirpur	30	15	50.00	15	7	46.66	15	5	33.33	15	3	20.00
Kangra	200	44	22.00	50	31	62.00	50	34	68.00	50	38	76.00
Kinnaur	100	9	9.00	10	8	80.00	10	6	60.00	10	4	40.00
Kullu	190	22	11.58	40	31	77.05	40	15	37.05	40	32	80.00
L & Spiti	40	—	--	10	1	10.00	10	1	10.00	10	1	10.00
Nandi	540	79	14.63	100	60	60.00	100	53	53.00	100	49	49.00
Shimla	600	81	13.50	100	44	44.00	100	48	48.00	100	62	62.00
Sirmaur	550	47	8.54	50	42	84.00	60	41	68.33	60	67	110.00
Solan	50	22	44.00	15	13	86.67	15	11	73.33	15	15	100.00
Una	10	6	60.00	15	6	40.00	10	5	50.00	10	7	70.00
Institutions												
i) I.G.H (U.C)	40	28	70.00	—	26	--	--	14	--	--	--	--
ii) I.G.M.C	--	--	--	—	--	--	--	30	--	—	--	--
HP State	3000	401	13.37	500	319	63.08	500	291	58.02	500	308	61.06

Annexe 8

Dais Training Programme

Yearwise achievement made from 1975-76

Year	Target	Achievement	%age
1975-76	50	29	58.00
1976-77	50	53	106.00
1977-78	1000	1047	104.7
1978-79	500	447	89.4
1979-80	500	623	124.6
1980-81	1000	831	83.10
1981-82	1440	1283	89.09
1982-83	1750	1470	84.00
1983-84	1750	1120	64.00
1984-85	750	761	101.47
1985-86	500	802	160.40

District-wise number of Dais trained during and upto 1985-86

Name of the district	No. of Dais trained till 31.3.85 since inception of the programme	No.of Dais trained during and upto 1985-86	No.of Dais trained upto 31 March 86 since the inception of the programme
Bilaspur	701	89	790
Chamba	711	75	786
Hamirpur	372	178	550
Kangra	1897	35	1932
Kinnaur	153	35	188
Kullu	764	43	807
L & Spiti	97	14	111
Mandi	701	54	755
Shimla	743	40	783
Sirmaur	562	180	742
Solan	404	25	429
Una	559	34	593
HP State	7664	802	8466

Annexe 9

No. of beds available in various government institutions as on 31 03 1986 - with the breakup of availability in rural/urban areas

Sr.	District	Hospitals			Community Health centres			Rural Hospitals (upgraded PHCs)			Primary Health centres			Subsidiary Health centres			Civil dispensaries		
		R	U	T	R	U	T	R	U	T	R	U	T	R	U	T	R	U	T
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	Bilaspur	--	134	134	--	--	--	--	30	30	44	--	44	18	--	18	19	--	19
2	Chamba	--	233	233	20	--	20	70	--	70	48	--	48	--	--	--	6	--	6
3	Hamirpur	--	110	110	30	--	30	30	--	30	12	21	33	10	--	10	18	--	18
4	Kangra	50	426	476	30	--	30	90	--	90	120	16	136	10	--	10	40	--	40
5	Kinnaur	60	--	60	20	--	20	20	--	20	12	--	12	--	--	--	--	--	--
6	Kullu	--	110	110	--	30	30	30	--	30	44	--	44	--	--	--	8	--	8
7	L & Spiti	30	--	30	20	--	20	20	--	20	6	--	6	4	--	4	2	--	2
8	Mandi	--	318	318	60	38	98	60	--	60	88	--	88	--	--	--	17	--	17
9	Shimla	65	945	1010	30	30	60	30	--	30	56	30	86	12	--	12	30	3	33
10	Sirmaur	58	256	314	--	--	--	30	--	30	30	6	36	10	--	10	8	--	8
11	Solan	28	130	158	--	13	13	-	30	30	36	--	36	--	--	--	32	--	32
12	Una	10	110	120	30	--	30	--	30	30	18	6	24	--	--	--	5	--	5
HP State		301	2772	3073	240	111	351	380	90	470	514	79	593	64	--	64	185	3	188

Note : R = rural; U = Urban; T = Total

Annexe 10

Details of beds per thousand population available in HP

Sr No.	Name of District	Mid year estimated population(1986)	Total Beds available	Beds per 1000 population
1	Bilaspur	2,83,052	299	1.1
2	Chamba	3,50,828	548	1.6
3	Hamirpur	3,51,740	241	0.7
4	Kangra	11,17,020	1300	1.2
5	Kinnaur	65,783	185	2.8
6	Kullu	2,69,658	285	1.1
7	L & Spiti	34,935	86	2.5
8	Mandi	7,32,041	840	1.1
9	Shimla	5,70,510	1422	2.5
10	Sirmaur	3,48,643	494	1.4
11	Solan	3,48,510	809	2.3
12	Una	3,54,033	241	0.7
	Total - HP	48,26,753	6750	1.4

Annexe 11

Quarter-wise & Districtwise number of TB cases detected during the year 1985-86

Sr. No.	Districts	First quarter Apr-June 1985			Second quarter July-Sept 1985			Third quarter Oct-Dec. 1985			Fourth Quarter Jan-March 1986		
		Target	Achieved	%age	Target	Achieved	%age	Target	Achieved	%age	Target	Achieved	%age
1	Bilaspur	200	183	91.5	200	160	80.00	200	142	71.00	200	142	71.00
2	Chamba	250	320	128.0	250	221	88.4	250	176	70.4	250	239	95.6
3	Hamirpur	250	246	98.4	250	329	131.6	250	199	79.6	250	251	100.4
4	Kangra	550	559	101.64	550	772	140.36	550	482	87.64	550	571	103.82
5	Kinnaur	50	129	258.00	50	66	132.00	50	54	108.00	50	71	142.00
6	Kullu	200	272	136.00	200	260	130.00	200	161	80.5	200	282	141.00
7	L & Spiti	25	32	128.00	25	25	100.00	25	8	40.00	25	1	4.00
8	Mandi	425	435	102.35	425	413	97.18	425	300	70.59	425	435	102.35
9	Shimla	300	381	127.00	300	327	109.00	300	216	72.00	300	1030	343.33
10	Sirmaur	250	204	81.6	250	108	43.2	250	66	26.4	250	130	52.00
11	Solan	250	37	14.8	250	85	34.00	250	48	19.2	250	57	22.8
12	Una	250	138	55.2	250	115	46.00	250	67	26.8	250	102	40.8
Institutions													
i)	Tanda	250	407	162.8	250	303	121.2	250	168	67.2	250	387	154.8
ii)	Dharampur	250	358	143.2	250	318	127.2	250	230	92.00	250	251	100.4
	I G H(Shimla)	--	106	--	--	109	--	--	85	--	--	51	--
	I G M C(Shimla)	--	--	--	--	--	--	--	--	--	--	39	--
	H P State	3500	3807	108.77	3500	3611	103.17	3500	2402	68.63	3500	4039	115.4

Annexe 12

Position of doctors in Himachal Pradesh as on 31 March 1986

Districts	Hospitals		P H Cs		C H Cs		S H Cs		C Ds		Any others		Total		
	R	U	R	U	R	U	R	U	R	U	R	U	R	U	T
1 Bilaspur	--	19	9	3	--	--	2	--	14	1	--	--	25	23	48
2 Chamba	1	24	18	--	2	--	--	--	8	--	--	--	29	24	53
3 Hamirpur	--	21	8	11	3	--	4	--	12	--	--	--	27	32	59
4 Kangra	4	54	39	6	5	--	2	--	35	--	1	6	86	66	152
6 Kinnaur	8	--	2	--	2	--	1	--	1	--	2	--	16	--	16
7 Kullu	--	21	12	--	--	6	--	--	7	1	4	--	23	28	51
8 L & Spiti	4	--	2	--	2	--	1	--	3	--	2	--	14	--	14
9 Mandi	--	39	27	--	8	--	3	--	20	--	--	--	58	39	97
10 Shimla	4	41	18	--	3	4	5	--	22	4	--	--	52	49	101
11 Sirmaur	9	34	13	--	--	--	2	--	13	--	--	--	37	34	71
12 Solan	7	26	16	--	4	--	1	--	20	--	2	--	50	26	76
13 Una	--	23	5	3	4	--	2	--	11	1	--	1	22	28	50
Others															
Tanda	5	--	--	--	--	--	--	--	--	--	--	--	5	--	5
Dharampur	6	--	--	--	--	--	--	--	--	--	--	--	6	--	6
Igh	--	3	--	--	--	--	--	--	--	--	--	--	--	3	3
KNH	--	2	--	--	--	--	--	--	--	--	--	--	--	2	2
IGMC	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
HP State	48	307	169	23	33	10	23	--	166	7	--	7	450	354	804

R = Rural ; U = Urban ; T = Total

Annexe 13

District-wise, year-wise cataract operations done from 1982-83 to 1985-86.

Sr. No.	Districts	YEAR 1982-83 Target	Achieved	%age	1983-84 Target	Achieved	%age	1984-85 Target	Achieved	%age	1985-86 Target	Achieved	%age
1	Bilaspur	489	1268	269.30	350	178	50.86	350	424	121.14	525	301	57.33
2	Chamba	619	464	74.96	430	240	55.81	430	202	46.97	600	250	43.00
3	Hamirpur	630	641	101.75	450	457	101.55	450	526	116.89	575	584	101.56
4	Kangra	1931	1078	55.82	1390	877	63.09	1390	780	56.11	1650	1269	76.91
5	Kinnaur	120	--	--	90	77	85.55	90	81	90.80	150	25	16.67
6	Kullu	478	214	44.77	330	167	50.60	330	358	105.48	475	386	81.26
7	L & Spiti	64	--	--	40	17	42.5	40	3	7.5	50	62	12.40
8	Mandi	1282	876	68.33	900	274	30.44	900	427	47.44	1125	555	49.33
9	Shimla	1015	560	55.17	720	226	31.39	720	767	106.53	1050	793	75.52
10	Sirmaur	612	188	30.71	430	224	52.99	430	432	100.46	625	429	68.64
11	Solan	603	494	81.92	420	308	73.33	420	529	125.95	575	377	65.56
12	Una	632	620	98.10	450	755	167.78	450	745	165.55	600	753	125.5
Institutions													
i)	IGH	--	794	--	--	220	--	--	--	--	--	--	--
ii)	Others	--	121	--	--	31	--	--	462	--	--	301	--
HP State		8475	7318	86.34	6000	4051	67.52	6000	5736	95.6	8000	6093	76.16

Annexe 14

Districtwise & Yearwise new TB cases detected under TB control programme from 1982-83 to 1985-86

Sr No.	Districts	YEAR 1982-83 Target	1982-83 Achieved	1982-83 %age	1983-84 Target	1983-84 Achieved	1983-84 %age	1984-85 Target	1984-85 Achieved	1984-85 %age	1985-86 Target	1985-86 Achieved	1985-86 % age
1	Bilaspur	577	616	106.75	721	816	113.17	793	656	82.72	800	627	78.37
2	Chamba	731	1475	201.77	914	1179	128.99	1005	1029	102.39	1000	956	95.6
3	Hamirpur	743	937	126.1	929	933	100.43	1021	1188	116.36	1000	1025	102.5
4	Kinnaur	140	109	77.85	175	452	258.28	192	415	216.15	200	320	160.00
5	Kangra	2270	2067	91.05	2838	1982	69.84	3121	1909	61.17	3200	2384	74.5
6	Kullu	564	1063	188.47	705	1057	149.52	775	905	116.77	800	975	121.87
7	L & Spiti	76	40	52.63	95	39	41.05	104	87	83.65	100	66	66.00
8	Mandi	1513	1712	113.15	1891	2069	109.41	2085	1867	89.54	2100	1583	75.38
9	Shimla	1198	1590	132.72	1497	1985	132.59	1646	2321	141.00	1750	1954	111.66
10	Sirmaur	722	580	80.33	902	732	81.15	992	518	52.21	1000	508	50.8
11	Solan	720	1349	187.36	901	326	36.18	991	264	26.64	1000	227	22.7
12	Una	746	362	48.52	932	446	47.85	1025	393	38.34	1050	422	40.19
INSTITUTIONS													
i)	MS Dharampur	--	--	--	--	1166	--	--	1210	--	--	1157	--
ii)	MS Tanda	--	--	--	--	1178	--	--	1282	--	--	1265	--
iii)	I G H Shimla	--	--	--	--	358	--	--	446	--	--	351	--
iv)	I G Medical College Shimla	--	--	--	--	--	--	--	550	--	--	39	--
H P State		10000	11900	119.00	12500	14718	117.74	13760	15040	109.38	14000	13859	98.99

Annexe 15

LIST OF TRAINING INSTITUTIONS OF HEALTH & FAMILY WELFARE DEPARTMENT, HIMACHAL PRADESH

District	Sr. No.	Name of the institutions	Block	Tehsil	Constituency	Area	Management
1	2	3	4	5	6	7	8
I MEDICAL COLLEGES							
Shimla	1	Indira Gandhi Medical College, Shimla	Kasumpti-Seoni.	Shimla	Shimla	Urban	Government
II GENERAL NURSING COURSE CENTRES							
Bilaspur	1	Distt. Hospital, Bilaspur	Bilaspur-Sadar	Bilaspur	Bilaspur	Urban	Government
Mandi	2	Distt. Hospital, Mandi	Mandi-Sadar	Mandi	Mandi	Urban	Government
Shimla	3	Indira Gandhi Hospital, Shimla	Kasumpti-Seoni	Shimla	Shimla	Urban	Government
III MULTIPURPOSE HEALTH WORKERS TRAINING SCHOOLS(MALES)							
Hamirpur	1	M P W Training School, Hamirpur.	Hamirpur	Hamipur	Hamirpur	Urban	Government
Kullu	2	M P W Training School, Kullu	Kullu	Kullu	Kullu	Urban	Government
Shimla	3	MPW Training School, Mashobra	Kasumpti-Seoni	Shimla	Kasumpti-Seoni.	Rural	Government
	4	MPW Training School, Parimahal	Kasumpti-Seoni	Shimla	Kasumpti-Seoni	Rural	Government
IV MULTIPURPOSE HEALTH WORKERS TRAINING SCHOOLS (FEMALE)							
Chamba	1	MPW Training School,Chamba	Chamba	Chamba	Chamba	Urban	Government
Hamirpur	2	MPW Training School, Hamirpur	Hamirpur	Hamirpur	Hamirpur	Urban	Government
Kangra	3	MPW Training School, Dharamsala	Rait	Kangra	Dharmsala	Urban	Government
	4	MPW Training School, Sidhbari	Rait	Kangra	Dharamsala	Rural	Mission
Kullu	5	MPW Training School, Kullu	Kullu	Kullu	Kullu	Urban	Government

1	2	3	4	5	6	7	8
IV	MULTIPURPOSE HEALTH WORKERS TRAINING SCHOOLS(FEMALE) - contd.						
Mandi	6	MPW Training School, Mandi	Mandi-Sadar	Mandi	Mandi	Urban	Government
Sirmaur	7	MPW Training School, Nahan	Nahan	Nahan	Nahan	Urban	Government
Solan	8	MPW Training School, Solan	Solan	Solan	Solan	Urban	Government
V	RADIOGRAPHER TRAINING CENTRE						
Shimla	1	Indira Gandhi Medical College, Shimla	Kasumpti-Seoni	Shimla	Shimla	Urban	Government
VI	TRAINING CENTRE FOR OPTHALMIC ASSISTANTS						
Shimla	1	Indira Gandhi Medical College, Shimla	Kasumpti-Seoni	Shimla	Shimla	Urban	Government
VII	LABORATORY TECHNICIANS TRAINING CENTRES						
Bilaspur	1	Distt.Hospital, Bilaspur	Bilaspur-Sadar	Bilaspur	Bilaspur	Urban	Government
Hamirpur	2	Distt.Hospital, Hamirpur	Hamirpur	Hamirpur	Hamirpur	Urban	Government
Kangra	3	Distt.Hospital, Dharamsala	Rait	Kangra	Dharamsala	Urban	Government
	4	T B Sanatorium, Tanda	Nagrota	Kangra	Nagrota	Rural	Government
Mandi	5	Distt.Hospital, Mandi	Mandisadsar	Mandi	Mandi	Urban	Government
Shimla	6	Indira Gandhi Hospital, Shimla.	Kasumpti-Seoni	Shimla	Shimla	Urban	Government
	7	Distt.Hospital, Nahan	Nahan	Nahan	Nahan	Urban	Government
VIII	PROMOTIONAL TRAINING SCHOOL FOR FEMALE SUPERVISORS						
Shimla	1	Promotional Training School, K N H Shimla.	Kasumpti-Seoni	Shimla	Shimla	Urban	Government
IX	TRAINING CENTRE FOR INSERVICE CANDIDATES						
Shimla	1	Health & Family Welfare Training Centre, Parimahal, Shimla	Kasumpti-Seoni	Shimla	Kasumpti	Rural	Government

Annexe 16

Names & addresses of participants in the workshop on National Health Policy held in Himachal Pradesh

I) Resource Persons, Facilitators, Organisers & Others

1 Mr Ajay Prasad
Secretary
Department of Health & Family Welfare
Government of Himchal Pradesh
Shimla (HP)

2 Dr Amla Rama Rao
Coordinator
Community Health Deptt,
Voluntary Health Association of India
40 Institutional Area(South of IIT)
New Delhi 110 016

3 Dr C L Malhotra
Director of Health Services
Government of Himachal Pradesh
Shimla (HP)

4 Dr Hardev Singh
Principal
Health & Family Welfare Training Centre
Pari Mahal
Shimla (HP)

5 Dr V K Bhargava
Director-cum-Principal
H P Medical College
Shimla (HP)

6 Mr M D Tyagi
Extension Officer
All India Radio
Shimla (HP)

7 Dr S K Dasgupta
Dy Director of Health Services
Shimla (HP)

8 Dr K L Kapoor
Chief Medical Officer
Hamirpur (HP)

9 Dr Prem Chand
Chief Medical Officer
Kullu (HP)

10 Dr B L Kapoor
Chief Medical Officer
Bilaspur (MP)

Annexe 16 : contd

11 Dr Brij Mohan Kapoor
Dy Director of Health Services,
Govt. of Himachal Pradesh
Shimla (HP)

12 Dr S K Vakil
Chief Medical Officer
Chamba (HP)

13 Dr Y C Fakay
Chief Medical Officer
Mandi (HP)

14 Dr V N Gupta
Asstt Director of Health Services
Govt of Himachal Pradesh
Shimla (HP)

15 Dr B S Sindhu
Asstt Director of Health Services
Govt. of Himachal Pradesh
Shimla (HP)

16 Dr B S Kakkar
Chief Medical Officer
Shimla (HP)

17 Dr Om Prakash
Dy Director of Health Services
Govt. of Himachal Pradesh
Shimla (HP)

18 Dr R M Bali
President, IMA - HP State Branch &
President of F.P Association of India, State Branch
Shimla (HP)

19 Dr D P Mohil
State Programme Officer(MCH-EPI)
Shimla (HP)

20 Dr M L Vaidya
Medical Officer of Health
Shimla (HP)

21 Ms Vanaja Ram Prasad
C/o. Voluntary Health Association of India
J.P. Nagar, 2nd Phase
Bangalore(Karnataka) 560 078
- (Based at Bangalore)

22 Dr Mira Shiva
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40 Institutional Area (South of IIT)
New Delhi 110 016

Annexe 16 - contd.

23 Dr N K Vaidya
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Indira Gandhi Medical College
Shimla (HP)

24 Mr Rakesh Kaushal
Dy Secretary
Deptt. of Health, Govt. of HP
Shimla (HP)

25 Dr Krishna Rahi
Medical Officer
T.M.I, Sanjauli
Shimla (HP)

26 Dr Sonam Lhama
Medical Officer
T.M.I., Sanjauli
Shimla (HP)

27 Dr P Dolma
Medical Officer
T.M.I., Sanjauli
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28 Dr S P Sareen
Medical Officer of Health
Sirmaur (HP)

29 Mr Kapil Dev Sood
Advocate, High Court
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30 Mr P N Goel
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31 Mr Darshan Shankar
Academy of Development Science
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PO Kashele
Karjat (Maharashtra)

32 Mr Ajay Singh
Administrator & Consultant to HPVHA (for National Health Policy Workshop)
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33 Mr Manphul Singh
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Annexe 16 - contd.

34 Mr Sanjay Sharma
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Annexe 16.1

II) Participants from Government Sector

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Kullu (HP)

2 Dr V I Singh
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7 Dr B S Rawal
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Annexe 16.2

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10 Mr S S Banolta
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Annexe 16.2 - contd

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15 Mr Amar Singh Kondal
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16 Mr Mohan Lal Sharma
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17 Mr Kuldeep Verma
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18 Mr Prem Verma
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20 Mr Subhash Mendhapurkar
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21 Mr V S Rana
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Kangra (HP)

VHAI

VOLUNTARY HEALTH ASSOCIATION OF INDIA assists in making community health a reality for all the people of India, with priority for the less privileged millions, with their involvement and participation, through the voluntary sector.

VHAI is a federation of voluntary health associations at the level of States, Regions and Union Territories, linking over 3000 health institutions and community health programmes. Its services are also available in non-affiliated areas.

Membership in VHAI and opportunity for its services are in principle open to all health institutions and associations in the voluntary, non-profit sector of health care irrespective of religious affiliations.

VHAI is a non-profit registered society. Its constitution is secular. It helps people to develop or extend community health services, or to add a community health component to general development projects.

VHAI educates the public on rational drug therapy, oral rehydration therapy, the value of mother and child welfare, the traditional systems of medicine and on smoking.

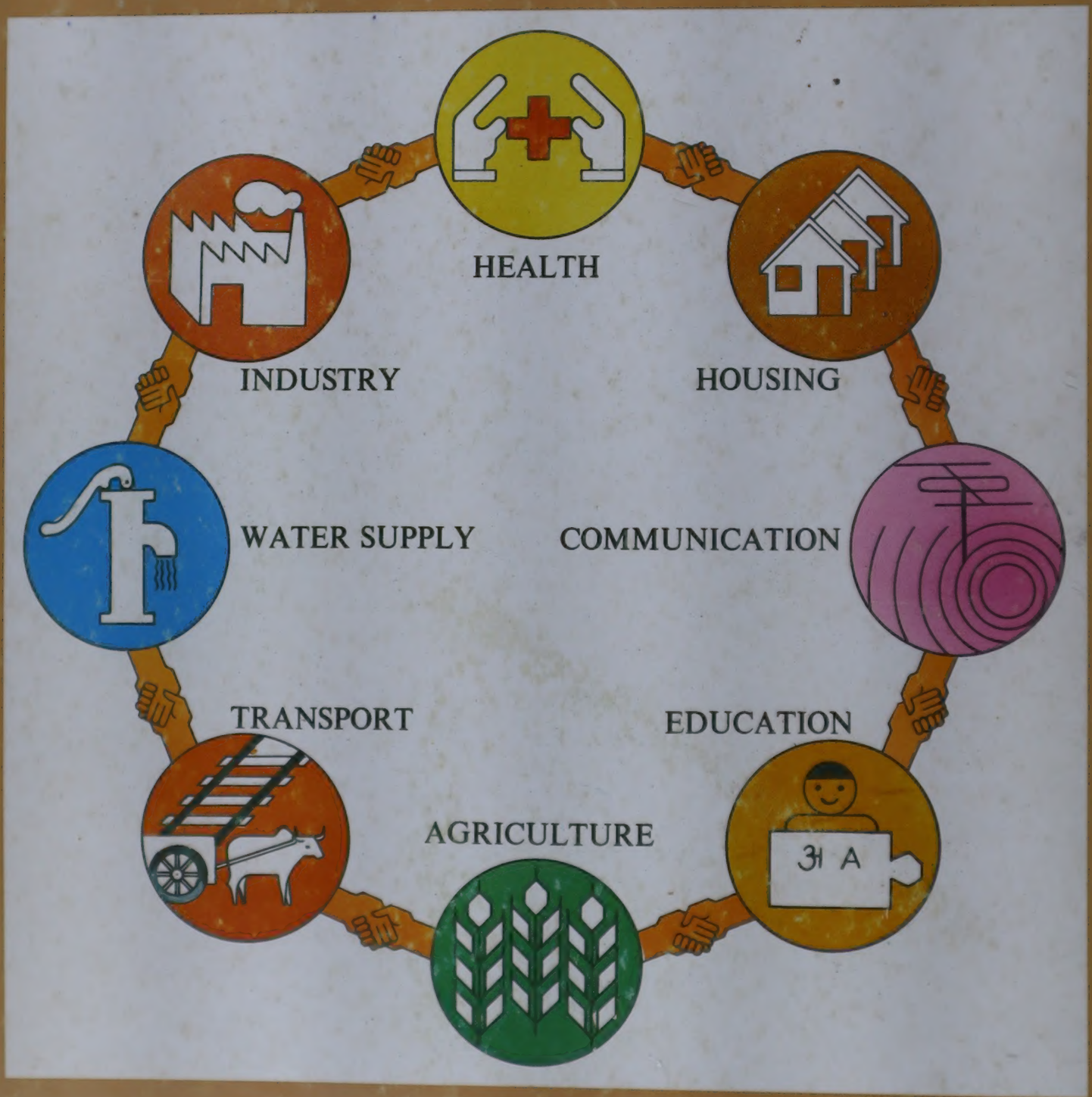
VHAI publishes books, pamphlets, fishcards, flannelgraphs, filmstips and slides.

VHAI collects, sifts, screens and distributes suitable health learning materials from all over the world.

VHAI trains various groups in producing health learning materials.

VHAI provides information on various health and related issues and trains various groups in information collection, documentation and dissemination.

Intersectoral Cooperation



This is a MUST to achieve Health for all by 2000 AD.